Release Date: March 26, 2007

THE PROVINCIAL COURT OF MANITOBA

IN THE MATTER OF: ***THE FATALITY INQUIRIES ACT***

AND IN THE MATTER OF: **DENNIS ROBINSON (deceased)**
(DOD: February 28, 2004)

Report on Inquest and Recommendations of
The Honourable Judge Brian M. Corrin
Issued this 21st day of March 2007

APPEARANCES:

Larry Hodgson, Inquest Counsel
Issie Frost and Jennifer Mann, Counsel for the Manitoba Developmental Centre, the Government of Manitoba, and the Department of Family Services and Housing
David Lewis, Counsel for the Manitoba Government Employees Union

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Paragraph(s)

INTRODUCTION

[1] Section 19(3) of **The Fatality Inquiries Act**, S.M.c.F52 provides that where an individual dies while a resident in a developmental centre as defined in **The Vulnerable Persons Living With a Mental Disability Act,** S.M. c.29 as a result of *"a violent act, undue means or negligence or in an unexpected or unexplained manner or suddenly of unknown cause"* the Chief Medical Examiner must direct a Provincial Judge to hold an inquest with respect to the death. The Chief Medical Examiner directed that Mr. Robinson's Inquest should determine the circumstances under which his death occurred, and determine what, if anything, can be done to prevent other deaths of a similar nature from occurring in the future.

[2] To assist in this task I heard evidence from a number of witnesses. Those included from the Manitoba Developmental Centre (MDC), Ms. Donna Bjore, the Chief Executive Officer, as well as all staff members who had contact with Mr. Robinson on the day in question. I also heard from several other administrative and supervisory staff members respecting policy and procedures at the Centre. Further testimony was received from RCMP Constable Kerri McKee and Dr. John Younes, a forensic pathologist.

[3] The Inquest hearings were held in Portage la Prairie on March 20th, 21st, 23rd, and 24th and May 8th, 9th, 10th and 11th, and June 19th and 21st, and October 3rd, 2006. Voluminous exhibits were filed (see Appendix C attached), including a new Policies and Procedures Manual (see Appendix B attached) that MDC has developed, in part, in response to Mr. Robinson's death. In all, forty-eight (48) exhibits were received in evidence.

[4] A standing hearing was held on May 27, 2005. Prior thereto, notice of same was mailed to Mr. Ryan Michael Mooney, Mr. Chris Simpkins and the deceased's next-of-kin, his brothers Ken and Rick Robinson. None of these parties sought standing at the Inquest. On application, the Government of Manitoba and MDC were granted standing as was the Manitoba Government Employees Union.

[5] At the completion of an inquest, **The Fatality Inquiries Act** requires that the presiding judge make and send a written report of the inquest to the Minister setting forth when, where and by what means the deceased person died, the cause of death and the name of the deceased person, and the material circumstances of the death. The provincial judge may also "recommend changes in the programs, policies or practices of the government and the relevant public agencies or institutions or in the laws of the province, where the presiding provincial judge is of the opinion that such changes would serve to reduce the likelihood of deaths in

circumstances similar to those that resulted in the death that is the subject of the inquest."

[6] The provincial judge providing a report at the end of the inquest must not express an opinion on or make a determination with respect to culpability in such a manner that a person is or could be reasonably identified as a culpable party in respect of the death that is the subject of the inquest. As a consequence of this limitation, the principal purpose of my work is to share critical information concerning safety issues as same came to light during the course of this Inquiry. Hopefully my work will provide information that will assist institutional care providers in preventing and reducing risks to residents under their care.

[7] I wish to take this opportunity to thank all counsel who participated in the Inquiry. Rest assured that you greatly assisted our undertaking. The able and seemingly tireless assistance of Inquest Counsel Larry Hodgson was particularly appreciated.

THE INCIDENT AND LIKELY CAUSE OF DEATH

[8] Dennis Robinson was a 52 year old male who was admitted to the Manitoba Developmental Centre (MDC) on April 2nd, 1958 at the age of six years. Prior to his admission, he had resided with his parents in Shoal Lake, Manitoba. On admission, he was determined to suffer profound mental retardation, most probably due to post-natal infection. His age equivalent intelligence/behaviour test score rated him at a two year intelligence level. Mr. Robinson had developed epilepsy as an adult and had suffered six seizures in 2003 and one in January 2004.

[9] On February 28, 2004, eight residents and two MDC staff members from Spruce Cottage went on a van outing around Portage la Prairie, MDC's home community. Half of the residents were diagnosed as suffering "severe" retardation and the other half suffered from what MDC classifies as "profound" retardation. One of these residents was deaf, four suffered from epilepsy, another suffered from a condition known as spastic athetosis, another suffered a condition known as spastic Quadra Paris. All the aforementioned residents required assistance with the basic activities entailed in daily living.

[10] After a couple of hours driving around Portage la Prairie, the van returned to MDC at approximately 3:00 p.m. The two staff members supervising the outing unloaded the residents/passengers at Spruce Cottage. The van was driven back to its normal parking spot a few minutes walk from Spruce Cottage. At approximately 3:40 p.m. a nurse was unable to locate Mr. Robinson to give him his medication. She requested other staff to conduct a search of the cottage premises. While this

was ongoing, one of the assisting staff members, aware that Mr. Robinson had been on the earlier van outing, went out to the parking lot to check the van. Shortly thereafter Mr. Robinson was located in what appeared to be an unconscious state in the van. An ambulance was called immediately but attending paramedics were unable to revive Mr. Robinson. He was transported to the Portage General Hospital where he was pronounced dead.

[11] An autopsy subsequently found that Mr. Robinson suffered from a significant narrowing of a major coronary artery, what was described as an 80% blockage. The Inquiry was told by Dr. John Younes, the forensic pathologist performing the autopsy, that Mr. Robinson likely died as a result of an epileptic seizure which led to cardiac arrhythmia (irregular heartbeat), which in turn caused a fatal oxygen deficiency in his heart. It was Dr. Younes' opinion that the arrhythmia seriously compromised Mr. Robinson's coronary function to the extent that his heart beat so fast that it couldn't fill up with sufficient blood to function. The Inquiry was told that Dr. Younes observed biting injuries to Mr. Robinson's tongue which he described as a common trauma for individuals experiencing epileptic seizure activity. The Inquiry learned that although there was no hard and fast rule, stress could produce the onslaught of epileptic seizures. We were also told that arrhythmia was definitely positively correlated to stress and that violent emotion could lead to the increases in heart blood pressure which cause this condition.

PROCEDURES IN PLACE AT TIME OF INCIDENT

[12] Prior to the February 28, 2004 incident date, the administration of MDC had compiled and circulated certain procedures which governed the supervision of residents on excursions outside the MDC premises. These procedures were filed as Exhibit 5 (Tab 3) at the Inquest. These procedures, as filed, are reproduced herewith as excerpted from Exhibit 5.

ORGANIZATION OF AND SUPERVISION OF RESIDENTS ON EXCURSIONS OUTSIDE THE MANITOBA DEVELOPMENTAL CENTRE	**MANITOBA DEVELOPMENTAL CENTRE** **NURSING PROCEDURES**
PROCEDURE	**RATIONALE**
1. Weather permitting, excursions outside the Centre may be planned i.e. park visits, picnics, hiking, zoo trips, etc.	1. Fresh Air and Exercise is important to the mental and physical well-being of the residents.
2. Before planning the outing, approval must be sought from the nurse in charge of the area and then the charge nurse must seek approval from the unit supervisor.	2. Approval must be sought so the unit supervisor is aware of the purpose of the outing and, also, so that they are aware of the whereabouts of residents and staff

The purpose of the outing must be identified at this time before any further organizing takes place.	at all times.
3. Once the outing has been approved by the proper authorities, an individual must be designated to be in charge. If the entire area is going, the charge nurse or designate will organize the outing and be in charge while on the outing. If a smaller group is going, the designated in charge person will assist the charge nurse with the organization of the outing and take total responsibility while on the outing. Staff also must be familiar with the elopement policy (B-5) prior to outing, in the event of elopement.	3. Organization of the outing is important so that all areas are covered and nothing is forgotten. The person who is going to be the person in charge on the outing should assist as much as possible in organizing it so they are aware of everything. Prior knowledge of policies/procedures will decrease anxiety and confusion in the event of elopement.
4. Arrangements for the transportation must be made through Mobile Department. It must be indicated who will be driving and where the destination is.	4. Staff and residents whereabouts are known in cases of emergencies.
5. If a picnic is planned, a catering requisition (D-31) must be filled in and sent to Dietary Department four (4) days prior to outing. (See Procedure H-3). If an outing to a restaurant is planned, money must be provided for the residents' meals. Extra fluids should be ordered from Dietary or purchased for the outing.	5. Prior notice allows for preparation of food. Ensures adequate food and fluids are available on outing.
6. An outing package should be kept on each area and should be brought on each outing. This package should contain the following: ▪ Copy of procedure; Record of specific outing. See appendix A; ▪ Copy of Dietary catering requisition; ▪ List of outing requirements (may vary from one area to another); ▪ Daily 15 minute Checklists - N-18; ▪ Restraint Checklist - N-6 (if required); ▪ Incidental Forms - CR-27; ▪ Nominal roll with high risk residents highlighted; ▪ List of what high risk residents	6. All pertinent information is readily available in case of emergency. Organization of necessary information prevents confusion in emergency situations.

are wearing; ▪ Writing paper; ▪ Pen or pencil; ▪ Resident characteristics; ▪ MAR sheets; ▪ Location and phone #'s in case of emergency. Upon arrival at the destination, the person in charge must make themselves aware of the closest hospital, RCMP, telephone so that help can be sought immediately in case of emergency. These places can be identified on the Record of Outing Outside the Manitoba Developmental Centre form - N29.	Awareness of these facilities minimizes confusion in the case of emergency.
7. All outings require a Record of Outing Outside the Centre be filled in and signed. Also a list of residents and staff responsible for which residents must be devised prior to outing. The high risk residents should be highlighted. eg. nominal roll.	7. Approving authority must be sought prior to outing ensuring the safety of everyone. Prior knowledge of high risk residents can prepare staff for possible incident.
8. All staff are to be aware of individual resident needs and characteristics. It is the nurses' responsibility to ensure that PNA's are aware of changes and risks involved. A 15 minute checklist (N-18) must be maintained at all times during the outing. When devising the list of residents and what staff are responsible for who, there may be high risk residents who may require constant supervision ie. elopement, no fear of water, etc. The staff assigned to these residents should have a smaller group. During outing the checklist must be initialed every 15 minutes, and it must be filled in when stopping at a destination ie. rest spot. The checklist must be done again when leaving the rest spot - even if 15 minutes has not elapsed. High risk residents must be with the staff assigned to them during the outing. Staff assigned to high risk residents are to receive instruction from charge nurse as to procedure re: that resident.	8. Ensures safety of each resident and whereabouts are known at all times.
9. Ensure adequate supplies of insect repellent, sunscreen, medications, first aid equipment, extra fluids must be available to use when	9. To ensure health and prevention of accidents.

necessary. Residents should be encouraged to use shade wherever available - especially between the hours of 10:00 - 14:00 hours. Clothing and footwear must be appropriate for weather and environment. Hats must be provided for those in the sun. Extra clothing and linen must be brought to use if necessary.	
10. Staff should be made aware of hazards in the environment and specific responsibilities identified.	10. Can prevent potential accidents.
11. All LOA medication required for outing must be brought on outing and administered at proper times.	11. To comply with routine medication regime.
12. Concerns must be made to nurse in charge and in the progress notes. If any unusual or untoward event takes place an incidental report (CR 27) must be completed. (Manitoba Developmental Centre policy/procedure I-40).	12. Communication of any concerns and/or unusual events.
Please Note: Procedure may vary from one area to another. This will be dictated by the type of resident living on the area.	

DETAILS OF THE INCIDENT

[13] On the morning of February 28, 2004, Psychiatric Nursing Assistants (PNAs) Chris Simpkins and Ryan Mooney, formulated a plan to take eight Spruce Cottage residents on a van outing to a local park that afternoon. Ryan Mooney documented the names of the eight residents who were going on the outing in the Cottage's Daily Journal. Residential Coordinator (the nurse in charge) Garry Bullock approved the outing, notwithstanding that he did not know the specifics of same. There was therefore no documentation in the Daily Journal to indicate the destination of the outing as required under then MDC Nursing Procedure F-5 (**Organization of and Supervision of Residents on Excursions Outside the Manitoba Developmental Centre**).

[14] It appears from the evidence received at the Inquest that only one of the residents was secured with a seat belt. None of the residents could do up or undo their own seat belts. This was contrary to MDC Policy I-131: Use of Seat Belts and Vehicle Wheelchair Restraints During Transportation and Policy I-130: Utilization of Government Vehicles. It was also a violation of **The Highway Traffic Act**.

[15] The checklist that was required by MDC Procedure F-5 (Organization of and Supervision of Residents on Excursions Outside the Manitoba Developmental Centre) to account for the presence of all passengers was not taken on the van outing.

[16] Shortly after departing from MDC, Mr. Simpkins drove the van to a sporting goods store. Mr. Mooney, who sat in the front row passenger seat next to Mr. Simpkins throughout the outing, went into the store on some personal business. Then, after stopping at a donut shop, where Mr. Simpkins and Mr. Mooney purchased a box of donut "eggs" for the resident passengers (contrary to a memo of May 23, 2003 from MDC Transport and Material Management - residents were not permitted to eat when being transported in a van). Mr. Simpkins then drove to Mr. Mooney's residence to determine if Mr. Mooney's girlfriend was there. The van then proceeded to a local car dealership in order to permit Mr. Simpkins to check the price of a vehicle that was for sale on the lot. After that stop Mr. Simpkins and Mr. Mooney decided to forego the trip to the park because they hadn't dressed the residents appropriately for the winter weather. After that they drove around for some time. They returned to MDC somewhere between 2:45 p.m. and 2:55 p.m. All but two residents required assistance getting off the van.

[17] Due to physical disability, Dennis Robinson could not have exited from the van without assistance. Mr. Robinson walked with an unsteady gait and required supervision and escort on stairs or uneven terrain. He used a walking belt and helmet during his waking hours in order to prevent injury due to falls. Not only did he require assistance walking but he was also known to be unaware of dangers present in his immediate environment. As a result of his mental disability he was non-verbal and could only make his needs known through gestures.

[18] Neither supervising PNA performed the necessary checklist head count at the end of the outing. This was yet another contravention of MDC Procedure F-5 (Organization of and Supervision of Residents on Excursions Outside the Manitoba Developmental Centre). Mr. Simpkins also failed to perform a check of the van upon returning it to the MDC compound, a contravention of MDC Policies I-131 and I-130 (Utilization of Government Vehicles). Although the purpose of this rule is to ensure that vehicles are left in a clean and roadworthy condition, it is noted that compliance would have required an inspection of the van's interior and consequent finding of Mr. Robinson. Mr. Simpkins filed a false vehicle inspection report at this time.

[19] At 3:40 p.m., the nurse in charge in Spruce Cottage, Ms. Shelley Turko, was unable to locate Mr. Robinson during her medication rounds. On her instruction, a

search commenced immediately. PNA Bruce Allen, having determined that Mr. Robinson had been on the van outing, ran over to the parking compound to inspect the vehicle that had been used that day. Upon arrival, he saw Mr. Robinson laying on the third row seat of the locked van, apparently unconscious, his upper body and head on the seat. Mr. Allen ran back to Spruce Cottage and informed others of his finding and asked staff to call 911. He then hurried back to the van with Nurse Turko. Once inside the van, Ms. Turko assessed the situation and commenced CPR. An ambulance arrived a few minutes later. The last known observation of Mr. Robinson alive and well was made by Mr. Mooney. In an interview with MDC staff on March 1, 2004 he said that he looked back and saw Mr. Robinson "chuckle" when the van went over a speed bump upon re-entering MDC.

MDC INVESTIGATION AND DISCIPLINARY PROCEEDINGS

[20] Following Mr. Robinson's death MDC conducted a formal investigation. The principals involved in same included MDC's Chief Executive Officer (CEO) Ms. Donna Bjore, its Human Rights Coordinator Mr. Richard Armstrong and Ms. Barbara Martens, the Director of the Geriatric Program. A short time later, comprehensive and detailed interviews were conducted with the various people involved in the incident.

[21] Shortly after the completion of their report on March 19, 2004, (the Martens Report), MDC acted on its recommendations, terminating the employment of Messrs. Simpkins and Mooney, the outing supervisors. Similarly Garry Bullock, the Spruce Cottage Nurse in Charge on the day of the outing, was given a letter of reprimand regarding his responsibility for certain aspects of the incident. The Nurse in Charge on the shift following the outing, Ms. Shelley Turko, although not formally disciplined, was given a letter of direction regarding her responsibility for certain aspects of the incident.

[22] Mr. Martin Billinkoff, Assistant Deputy Minister of Family Services and Housing, wrote to Messrs. Mooney and Simpkins on March 25, 2004 formally advising them of the results of the internal investigation and dismissing them from employment at MDC. The dismissals were based on gross negligence in the care of the eight residents taken on the outing, particularly Mr. Robinson. To quote directly from the letters, Mr. Billinkoff stated:

> "Your conduct and actions placed the residents at risk by not adhering to MDC policies and procedures and the *Highway Traffic Act*. This conduct is unacceptable and is not in keeping with standards of behaviour consistent with your function and role as a Psychiatric Nursing Assistant II."

[23] The following violations of MDC policies and procedures were cited by Mr. Billinkoff with respect to both Mr. Simpkins and Mr. Mooney:

- There was no documentation in the Daily Journal to indicate the destination of the outing and no checklist of any kind was taken on the van outing to be used to account for the presence of all the residents. You did not account for the eight residents when you returned to Spruce Cottage. *This is a contravention of MDC nursing procedure F-5: Organization of and Supervision of Residents on Excursions Outside the Manitoba Developmental Centre.*

- Mr. Simpkins purchased two coffees (one for himself and one for Mr. Mooney) with the residents' money and then both drank same in front of the residences. *This is a contravention of MDC Policy I-50 Protection-Resident Abuse/Neglect/Undignified Treatment and the Vulnerable Persons Act.*

- Residents were given and ate donut "eggs" in the van when the vehicle was moving creating an unsafe situation. *This is a contravention of memos from MDC Transportation and Material Management Supervisor of April 7, 2000 and May 23, 2000 Vehicle Security and Cleanliness.*

- Only one resident taken on the outing was wearing a seat belt. MDC Policy states that drivers and escorts are equally responsible to ensure that safety devices for residents are properly secured on outings. *This is a contravention of MDC Policies I-131: Use of Seat Belts and Vehicle Wheelchair Restraints During Transportation and I-130: Utilization of Government Vehicles and the Highway Traffic Act.*

- Mr. Simpkins, being the driver of the van, was also cited for failure to complete a check of the van on departure or on return from the outing, notwithstanding that the Return Checklist filed by him indicated that the van had been so checked. *This was found to be a contravention of MDC Policies: I-131 and I-130: Utilization of Government Vehicles.*

[24] Brenda Solomon, MDC's Director of the Specialty Care Program, issued a Letter of Reprimand to Mr. Garry Bullock on April 20th, 2004. In this regard, Ms. Solomon noted that it was Mr. Bullock's responsibility as the Psychiatric Nurse in charge of Spruce Cottage on the afternoon of the incident:

> ". . . to ensure the care and management of the residents at Spruce Cottage. It appears that you were not concerned with the difficult group that was scheduled to go out nor did you determine where they were going. Particularly, it is your responsibility to ensure that all the residents are accounted for before you go off shift by making a round of the cottages as indicated in Spruce Cottage routines. It is imperative that you follow this process thoroughly. Please be advised that management expects you to exercise sound clinical judgement (sic) when making decisions related to resident outings. You are accountable and responsible for the care and management of the residents at Spruce Cottage during your shift. Should similar situations occur in the future, you will subject yourself to more severe disciplinary action."

[25] Mr. Bullock had concluded his shift at 3:30 p.m. and left without doing his final rounds.

[26] Brenda Solomon also wrote a Letter of Direction to Licensed Practical Nurse Shelley Turko on April 20, 2004. In this regard, it was noted that:

> ". . . as a Nurse in Charge, it is your responsibility to ensure all residents are accounted for when you commence your shift. Therefore, the intent of this letter is to provide you with direction for the future. This direction is given because you are responsible and accountable for the care and management of the residents of Spruce Cottage. This letter is not disciplinary in nature but is intended to provide you with an opportunity to ensure that you fulfill your responsibility and accountability for the care and management of the residents under your charge and adhere to Spruce Cottage routines ensuring a round is made of the area and residents are all accounted for."

[27] Ms. Turko had commenced her shift at 3:30 p.m., approximately 10 minutes before she discovered Mr. Robinson to be missing.

[28] Mr. Simpkins being an MDC employee and covered by the terms of a Collective Agreement between the Province of Manitoba and the Manitoba Government Employees Union (MGEU) grieved his termination. The matter was put before a Board of Arbitration, comprised of a sole arbitrator, Mr. Paul Teskey, and hearings were conducted on various dates in 2004. Ultimately, Arbitrator Teskey reported his decision on February 28, 2005. Arbitrator Teskey ordered that the grievance be allowed and Mr. Simpkins be reinstated. Although he was to receive no retroactive compensation his seniority was bridged over the time from dismissal to the date of reinstatement. Arbitrator Teskey also ordered that Mr. Simpkins be required to take such re-training as MDC required.

[29] Arbitrator Teskey found that MDC Policies relating to the incident did "not appear to have been particularly enforced" and that:

> ". . . employees in a position such as the griever's are judged at a higher standard but not an impossible standard. People do make mistakes and there is a difference between intentional and unintentional acts. Consideration must always be given towards length of service and previous good record which are involved here. If Mr. Robinson had not died, I do not believe that the Employer's previous response with respect to such incidents would have resulted in termination. However, I do believe that the misconduct is serious and cumulative (and) that a very important 'wake up' call has to be established in this case."

[30] Arbitrator Teskey's reference to MDC's previous response, although unexplained, assumably must have been in reference to a similar incident which occurred on April 28, 2002 involving the abandonment of another resident in a van for two hours subsequent to an outing. On June 4, 2002, MDC issued a Letter of Discipline and one day suspension without pay to the responsible PNA. It was noted that the PNA's negligence "resulted in an unsafe situation that may have resulted in serious consequences to the health and wellbeing of the resident." The PNA's negligence was determined to be a breach of MDC Policy I-130 (Utilization of Government Vehicles and Nursing Procedure F-1: Outdoor Supervision of Residents).

[31] The PNA involved had taken three residents on a shopping trip. The caregiver, only on the job for 10 months, was unaware that MDC rules forbade a PNA1 from escorting an off-residence excursion without the presence and support of a PNA2. The Charge Nurse who approved the outing apparently assumed that a PNA2 would be present on the trip. The PNA1 failed to employ the resident checklist policy properly and consequently only brought two of her three charges back to their cottage. She also failed to sign in on her return. Apparently she believed that all three residents had gone off to church and that sign-in was therefore unnecessary. Management admittedly gave this employee a rather lenient disciplinary disposition. The Inquiry was told by way of explanation that this was done in response to the MGEU's concern that the policy mandating the presence of a PNA2 was unclear. Management, agreeing that the policy was somewhat vague and in need of clarification, therefore agreed to a lenient outcome. The Inquiry does not know if the Charge Nurse was also cited for neglect of duty in this regard.

POLICY AND PROCEDURAL CHANGES SUBSEQUENT TO THE INCIDENT

[32] Subsequent to the Robinson incident, on May 19th, 2004 (not after the incident described in the preceding paragraph) MDC made further resident protective changes to a number of pertinent policies and procedures. These "upgraded" policies, inclusive of the former rules, were disclosed by MDC to be as follows:

(For a detailed comparison of the pertinent rules and procedures in place before/after the incident, one should refer back to paragraph [12] and Appendix B.)

Introduction:

Former MDC Policies I-130 Utilization of Government Vehicles, MDC Policy I-131 Use of Seat Belts and Vehicle Wheelchair Restraints during Transportation and Clinical Nursing Policy and Procedures F-5 Organization of and Supervision of Residents on Excursions Outside of Manitoba Developmental Centre and F-4 Transportation of a Resident were reviewed by MDC stakeholders and Executive Management Committee. These policies have been incorporated into two replacement policies; one dealing with Supervision of Residents off MDC grounds (I-130) and the other with the Utilization of Motor Vehicles (I-131). The two new policies were approved by Executive Management Committee on May 19, 2004.

The policies were distributed to all staff on May 27, 2004 with the requirement to read and sign as understood. Policy I-130 Transportation of Residents off MDC Grounds clearly states that a binder with resident ID's and Form A-97 Accountability and Resident Outing Checklist (formerly part of Nursing Procedure F-5) MUST BE TAKEN on every outing regardless whether the residents stay in or get out of the vehicle. These policies were subsequently revised/approved as per MDC 2 year policy review schedule (I-130 June 13, 2006, I-131 May 31, 2006).

Residential Area Routines
Nursing Rounds Implemented Centre-wide:
Nursing Staff are required to make rounds of their residential area at shift changes (0715, 1515, 2315 hrs). Rounds must be made by one nursing staff from each shift. Residential Area Accountability Checklist (N-75) must be signed by both nursing staff. All residents are accounted for at shift change.

Outing Binder:
- *Executive Management Committee mandated that Outing Binders are to be used for every outing off MDC grounds (not at discretion of accompanying staff).*
- *Resident Clothing Identification Form A-96 added*
- *Forms A-97(a) and A-97(b) were revised*
- *Form MB Departure and Return Checklist revised and included in the Outing Binder.*
- *Resident ID Cards must be included in the Outing Binder*

Policy 1-130 Supervision of Residents off MDC Grounds.

- *All service providers are required to read, understand and abide by MDC Policy I-131 Utilization of Motor Vehicles on Government Business*
- *Form A-97(b) Record of Trips outside the MDC incorporated from Nursing Procedure F-5 into Policy I-130. An appropriate service provider must be designated to be in charge and the service provider in charge is responsible for ensuring that all forms are completed. The nurse in charge of the area will ensure that the information is complete and sign the forms prior to departure. Form to be kept for 30 days.*
- *Escorting service providers will position themselves with residents at back and middle of vehicle to enable close supervision and safety of residents.*
- *Cell phones must be taken on every outing for emergency use.*
- *Cell phones, whether personal or government issued must not be used by the driver while the vehicle is in motion.*
- *The booking sheet must be signed when picking up the cell phone and adapter cord. Check to ensure the phone works. The cell phone number must be left with the residential area and the phone is to be turned on at all times. If everyone from the residential area is on the outing, the cell phone number must be left with Switchboard.*
- *No food will be consumed in MDC fleet vehicles with exception of puddings, etc. for medication. Fluids may be consumed in a stopped vehicle on discretion of person in charge of outing.*
- *Form revised to ensure all residents accounted for upon departure and return from each trip and whenever residents are out of the vehicle. If the resident head count numbers differ, the reason must be clearly stated on the Departure and Return Checklist. Departure and Return checklist MB-7 was included in Policy I-130 as well as Policy I-131*
- *Resident's IDs must be included in Outing Binder*
- *Form A-97(a) Accountability and Resident Outing Checklist (Nursing Procedure F-5) revised and incorporated into Policy I-130. Nurse in Charge will ensure all residents are accounted for on return and sign the form. Form kept for 30 days.*
- *Residents must be seated appropriately based on behaviour, medical condition, or safety reasons and not interfere with the driver.*
- *Escorting service providers will position themselves with residents at back and middle of vehicle to enable close supervision and safety of residents.*
- *Form A-96 Resident Clothing Identification list added to the Outing Binder*

Utilization of Motor Vehicles on Government Business Policy I-131 (approved May 19, 2004)

- *Policy statements related to utilization of Government Vehicles from former MDC Policies I-130, I-131, I-132 and I-140 and Nursing Policies F-4 and F-5 were incorporated into a new policy I-131 Utilization of Motor Vehicles on Government Business.*
- *When transporting residents, all service providers are required to read and understand MDC Policy I-130 Supervision of Residents off MDC Grounds.*
- *Cell phones must be taken on every outing for emergency use.*
- *The cell phone number must be left with the residential area and the phone turned on. If everyone from the residential area is on the outing, then the cell phone number must be left with Switchboard.*
- *Absolutely NO Cell phones whether personal or government issued will be used by the driver while the vehicle is in motion.*

- *No food will be consumed in the MDC fleet vehicles, with the exception of pudding for medication. Fluids may be consumed in a stopped vehicle at the discretion of the person in charge of the outing.*
- *Departure and Return Checklist form MB-7 revised to ensure all residents accounted for upon departure and return from each trip and whenever residents are out of the vehicle. If the resident head count numbers differ, the reason must be clearly stated on the Departure and Return Checklist. Seats and floor must be inspected and litter removed. Survival kit and handicap parking pass accounted for.*
- *The Transportation and Material Management Supervisor or delegate will advise the appropriate Residential Coordinator/supervisor/manager of any policy infraction related to the Departure/Return Checklist.*

Nursing Policy F-5 removed from Nursing Policy Manual and incorporated into Centre-wide Policy 1-130

Nursing Policy F-4 Administration of Medication by a non-nurse service provider.

The following change was made:

- *Staff must take a cell phone with them (as per Policy I-130) in order to communicate with a nurse at the Centre if concerns arise while away from the Centre.*

Policy I-40 Incident/Risk Reporting

No change to existing policy except for the following statement:

- *Ensure the date and time information is completed accurately*

Policy I-50 Protection – Resident Abuse/Neglect/Undignified Treatment

No change to existing Policy except for the following:

- *"Failure to report may lead to disciplinary action" added to existing policy statement #2*
- *In addition to reporting incident to his/her supervisor, staff are required to complete an Incident Risk Report A-90 prior to the end of his/her shift.*

[33] The actual "boiled down" changes are essentially as follows:

- One staff escort must always sit in the middle or back of the van. (Rule 13-130) If more than one escort, at the middle **and** back.

- The Resident Identification Binder and Resident Outing Checklist must now be utilized on all outings regardless of whether the residents are to exit **or** remain in the van. (Rule 11-130) Although this would not have pertained to the incident it does serve to clarify a previously "gray area".

- All residents must not only be accounted for upon departure and return from an outing but also when residents are outside the vehicle. (Rule 10-130)

- The cottage Residential Coordinator/Nurse in charge, in consultation with service providers involved in transport, determines the escort needs in addition to the driver.

- A residential outing binder containing: Resident ID's, Form A.97(a); Accountability and Resident Outing Checklist, Form A.97(b); a Record of Trip Outside the Manitoba Developmental Centre; as well as new Form A.96 Resident Clothing Identification, must be carried by staff on all outings. The service provider in charge is now unambiguously described as the staff person responsible for ensuring that all forms are properly completed. All these documents must now be kept on file for a minimum one month period. (See Appendix D for binder contents.)

- A requirement that the nursing staff member doing rounds at a shift change not only perform a resident head count but actually sign off attesting to having done same.

- Cell phones must be taken on all outings for emergency use.

- Form A.97 Record of Outing Outside MDC must now be signed by cottage supervisor in box entitled "Authorized by" and not a PNA staff outing escort. As well, the staff escort person in charge of the outing must now sign off on Form A.96 Accountability and Resident Outing Checklist that all residents have been returned and accounted for. I observe that resident lists were always required to be made prior to departure on an outing in order that required head counts could be made periodically during the outing as well as at the beginning and ending of the excursion.

- Residents on excursion must be seated appropriately based on behaviour, medical condition or safety reasons.

DISCUSSION AND ANALYSIS OF ISSUES ARISING FROM INQUIRY

Failure of Staff to Follow MDC Policies and Procedures

[34] As previously discussed, Mr. Robinson's abandonment would not have occurred if staff had followed the pertinent policies and procedures that existed in February 2004. For example, compliance with the rule requiring the keeping of a 15 minute checklist would have ensured that supervisory staff would have known the whereabouts of Mr. Robinson at all times. On cross-examination, Mr. Simpkins listed the names of approximately a dozen other employees who had been on resident outings with him when such checklists hadn't been kept. He also told the Inquiry that when he did take the trouble to maintain a checklist he would throw it away after the excursion as no rule required that escorting staff file it. Ryan Mooney told the Inquiry that he'd never seen any staff person fill out a 15 minute checklist except when the entire cottage went out en masse.

[35] Other significant rules were also breached. For example, the requirement that all service providers, both driver and escort, ensure that all resident passengers be securely belted before putting the trip vehicle in motion. Although only one passenger on the subject outing had been belted (by Mr. Simpkins), Mr. Mooney told the Inquiry that he assumed that Mr. Simpkins had done up everyone. The Inquiry was informed that neither Mr. Simpkins nor Mr. Mooney made a regular practice of following the seat restraint rule notwithstanding their familiarity with same. Indeed, several witnesses told the Inquiry that staff observance of this rule was generally inconsistent. One witness, a PNA2, described seat belt disuse as one of the "top ones" when describing areas of serious staff neglect. A senior psychiatric nurse admitted that he hadn't followed the MDC Nursing Procedures Manual regarding excursions on many occasions. Somewhat ironically the Inquiry was advised by management that staff are encouraged to report unsafe conditions during ongoing professional training sessions. Another witness, a senior nurse, advised that staff don't like to rock the boat in this regard and that whistle blowing is generally frowned upon. Another senior caregiver, one who had failed to mention Garry Bullock's transgressions in relation to this incident in a subsequent performance appraisal, explained that she had chosen not to do so because it was her opinion that he'd learned his lesson. She then went on to explain that it was very difficult to criticize staff colleagues because of "collegiality." Mr. Bullock was reprimanded by MDC for failing to perform his end of shift resident head count just minutes after the Spruce Cottage excursion party returned to the residence.

[36] There are approximately 750 permanent full and part-time permanent and term staff at MDC. All staff are exposed to workplace orientation shortly after

appointment. Such orientation obliges all new employees to familiarize themselves with key policy and procedure manuals. Regular assessments are performed thereafter. Ryan Mooney's August 2003 assessment (Inquiry Exhibit 21) stated that he ensures a safe and secure environment at all times – ensures that safety concerns are reported. This was obviously contradicted by his own testimony at the Inquiry.

[37] MDC maintains ongoing staff training improvement programming and receives high accreditation marks from national accreditation authorities. Indeed, the Inquiry received evidence that national accreditations rate MDC highly with respect to meeting residents' collective and individual needs and that other similar institutions both copy and actually utilize the MDC staff training format. It is therefore apparent that knowledge of policies and procedures in and of itself does not guarantee staff compliance.

[38] The Inquiry learned that MDC does not as a matter of practice publicize the consequences of disciplinary proceedings. For instance, a 2002 decision to suspend a staff member for one day for leaving a resident in a vehicle for a couple of hours was never communicated to other employees. Management witnesses testified that they are of the view that employee confidentiality trumps all other concerns and that they have never reported the outcome of such proceedings even in the most general format absent identifying information. Disciplinary outcomes/decisions imposed by management with respect to employee misconduct or performance deficiencies have therefore no general impact beyond personal deterrence in relation to the staff person being disciplined and consequently have no general deterrent impact on the MDC staff whatsoever. They are unknown to all but the M.G.E.U. and the individual affected.

[39] A registered psychiatric nurse testified that she felt that publication of disciplinary proceedings would be beneficial to the workplace as it would act as a deterrent and prevent other staff from committing the same or similar workplace violations.

Hiring Practises

[40] MDC is a relatively large and complex public institution employing approximately 750 staff. Of these, 410 are permanent full-time, 108 are permanent part-time, 80 are full-time term, 48 are part-time term, 86 are casual, 8 are seasonally employed STEP students and 5 work in Human Resources per se. Of this number, there are approximately 200 PNA2s (senior psychiatric nursing assistants) and 100 nurses.

[41] The Inquiry was told that the Civil Service Commission delegates authority to MDC to screen, interview and hire candidates for job positions. In order to ensure compliance with Civil Service Commission standards, the Commission performs a random audit of new employee files approximately every three years. Human Resource personnel at MDC do a number of things to solicit job applicants. These include bi-annual advertisements in local (Portage la Prairie) newspapers, permanent postings at the E.I. office (Portage la Prairie), annual participation in two local high school "career day" events and posting at the Portage la Prairie Friendship Centre as well as involvement with a Dakota Plains First Nation agency doing employment counseling. The Inquiry was told that MDC holds all such applications on file for 3-6 months in order to conform with **The Civil Service Act**. Applicants are permitted to attend or phone MDC to extend and update their applications.

[42] MDC doesn't make a practice of posting term jobs, preferring to retain a folio of applications which are reviewed when PNA term positions actually become available. (Mr. Richard Armstrong, MDC Human Resource Coordinator, informed the Inquiry that no government policy requires that entry level positions be publicly bulletined.) At such time, "inventoried" applications are screened against screening criteria for general suitability. The only minimum requirement for screening review is first aid certification. Applicants possessing appropriate training, Health Care Aide certification, are not necessarily interviewed.
A minimum of two MDC management staff must participate in each hiring panel. Since MDC has a fairly significant number of family related staffers, prospective panelists must disqualify themselves if they have a conflict of interest in this regard. This was a concern in Ryan Mooney's interview since both his parents were employed at MDC at the time. A list of essential and preferred criteria is established prior to the commencement of the interview process. This is governed by guidelines which are published by the Civil Service Commission (see Appendix E). At the conclusion of the interviewing phase which follows the same preset interview guide for each applicant, the candidates are rated as per the selection criteria for the position. Successful candidates' references are then checked before final selection is made. At this stage a Human Resources manager audits the panelists' notes to ensure that all interviewees were asked the same questions and that non-selected candidates were eliminated reasonably and in good faith.

[43] Ryan Mooney applied to work at MDC on October 19th, 2000. Mr. Mooney was one of 16 applicants who were interviewed on or about November 1st, 2000 respecting nine term openings for PNA1 entry level positions (a PNA job description can be found at Appendix F). MDC doesn't outside hire PNA2s,

preferring to limit access to that level to persons who have met Civil Service Commission standards for permanent civil service positions, i.e., two years of satisfactory term service. Virtually all PNA2s are therefore “promoted” from the PNA1 ranks. MDC administration witnesses told the Inquiry that new staff were evaluated after serving three, six and 12 months, then annually until they attained permanent PNA2 status.

[44] Unlike a number of other applicants selected for interviewing, Mr. Mooney did not possess any related job experience or a certificate qualifying him as a trained health care aide or a developmental service worker. Although these were “preferred” screening criteria they were not formally designated as “essential” selection criteria for the PNA position he applied for. His formal employment background which began in 1997 included a short stint as a retail clerk at an auto parts store and two years at Maple Leaf Foods where he was employed as a machine operator and shipper/receiver. His prior experience with persons who had long term care or special needs concerns was limited to a school classmate who had epilepsy and a friend who was deaf.

[45] Unsuccessful applicants are informed of outcomes after the completion of the panel process but are not provided any reasons for not being selected. They are not formally advised that they are entitled to appeal pursuant to applicable Civil Service Commission legislation although such information is of course provided by MDC if they take the initiative of inquiring as to their rights in such regard.

[46] One can readily deduce from the evidence received at this Inquiry that Mr. Mooney was quite possibly ill-suited to work as a caregiver at MDC. Indeed, one of his workplace supervisors actually described him as being “not that caring” when interviewed by an MDC investigator on March 8, 2004, just a week or so after the incident. Given his lack of related experience and training, I must conclude that his chances of securing employment would have been significantly reduced if MDC had cast a wider net in its employee hiring practices. Indeed, if MDC were to adopt different screening criteria, he might have been eliminated from the application pool prior to the interview stage. For instance, a requirement that applicants possess either health care certification or past group home or care facility experience as a basic qualification would have effectively eliminated Mr. Mooney from competition. It is noteworthy that another applicant in the same competition pool was eliminated because she didn’t impress the panel as being sufficiently compassionate notwithstanding that she had years of service in the personal care profession. A witness who served on the selection panel advised the Inquiry that no efforts were made to explore this concern by calling any of her former employers.

[47] Advertising the PNA competitions province-wide for suitable candidates would most probably result in a better qualified list of applicants. This would be particularly so if the appropriate screening criteria, i.e., related job experience or training as a health care aide were included in the advertisement. Another obvious benefit that would follow from such an approach would be the reduction of conflict situations involving panelists who had close ties with applicants' family members currently on staff.

Use of Seat Belts

[48] The Inquiry determined that on the day of the incident only one of eight passengers, four of whom were diagnosed as suffering from severe mental retardation and the other four from profound retardation, was restrained by a seat belt. As previously mentioned, MDC polices in force at the time required all van drivers to ensure that all passengers were restrained with seat belts.

[49] It is obvious that the rule in question is sound from a safety standpoint as no other protection of handicapped persons is provided for by Manitoba law. Indeed, the relevant provisions of **The Highway Traffic Act** place no such responsibility on drivers unless passengers are between five and eighteen years (or under the age of five if the child weighs more than fifty pounds). The relevant provisions of the aforementioned legislation are as follows:

> **Seat belt required by passenger**
>
> 186(4) Subject to subsection (5), every person who is a passenger in a motor vehicle while it is being driven on a highway in which a seat belt assembly is provided for seating positions occupied by the passenger shall wear the complete seat belt assembly in a properly adjusted and securely fastened manner; but where a seat belt assembly consists of a separate pelvic and a torso restraint the person may wear the pelvic restraint only.
>
> **Age restriction**
>
> 186(6) Subject to subsection (7), no person shall drive on a highway a motor vehicle in which there is a passenger
>
> (a) who has attained the age of at least 5 years but has not yet attained the age of 18 years; or
>
> (b) who is under the age of 5 years but whose weight exceeds 50 pounds;
>
> and who occupies a seating position for which a seat belt assembly is provided, unless that passenger is wearing the complete seat belt assembly in a properly adjusted and securely fastened manner; but where the seat belt assembly consists of a separate pelvic and torso restraint, the passenger may wear the pelvic restraint only.

Medical or physical restrictions

186(7) Subsection (6) does not apply where the passenger

(a) holds a certificate signed by a qualified medical practitioner certifying that the person is, during the period stated in the certificate, unable for medical reasons to wear a seat belt assembly, and on request made by a peace officer produces the certificate;

(b) is, to the satisfaction of a peace officer, of such size or build or possesses such other physical characteristics that he is unable to wear a seat belt assembly;

(c) is engaged in work which requires him to alight from and re-enter the motor vehicle at frequent intervals and the motor vehicle is not being driven at a speed exceeding 40 kilometres per hour; or

(d) is in the care or custody of a peace officer.

Driving while on duty

186(8) Subsections (3), (4) and (6) do not apply to

(a) a peace officer who in the lawful performance of his duty, is transporting a person in his care or custody;

(b) a driver where he is transporting a passenger for hire in a taxicab or livery; or

(c) a medical attendant where he is transporting a patient in an ambulance.

Child restraints required

186(9) No person shall operate, or permit the operation of, a motor vehicle on a highway unless every passenger in the vehicle who has not yet attained the age of 5 years and who is under 50 pounds in weight is properly secured in a restraining device of a kind prescribed in the regulations and the device is properly secured to the motor vehicle.

[50] The legislation's failure to protect mentally challenged persons is a glaring deficiency that needs to be addressed. The deceased, Mr. Robinson, had a mental age of approximately two years and was described by witnesses as being completely unable to fasten a seat belt.

[51] Indeed, Mr. Robinson was so profoundly disabled that he could only communicate with gestures. Persons professionally involved in the care and transport of vulnerable persons of this description should be required to be responsible for their well-being and protection. Accordingly, it is recommended that the provincial legislature amend section 186(6) of **The Highway Traffic Act** to include mentally challenged persons as a protected category.

The Conundrum of Caregiver Training and MDC Policy Compliance

[52] At the conclusion of the Inquiry, the Crown raised concerns about both the adequacy and efficacy of MDC's staff training methodology. Given the context of the incident this certainly seems warranted. As previously described herein, there were numerous and sometimes seemingly inexplicable breaches of pertinent MDC procedures designed to promote resident safety. These breaches involved four staff members, two of whom were very senior employees of the institution.

[53] Performance appraisals of the four had been unexceptional with each possessing a previous good employment record with the exception of one minor and wholly unrelated incident. Suffice to say that there is ample evidence from which one can reasonably conclude that all of the offenders were familiar with the various MDC safety policies pertaining to the outing. That being said, there was also clear evidence that MDC often employs PNAs with no particular vocational training or related background although the Inquiry was told that a Health Care Aide Certificate and/or related experience are desired employment attributes. Neither Mr. Simpkins nor Mr. Mooney possessed either of these when they were hired. Indeed, neither possessed any of the other preferred criteria, preferred training or experience backgrounds either, i.e., paid or volunteer personal care experience or a Health Care Aide certification. Interestingly, one of the applicants rejected on Mr. Mooney's round of appointments had prior work experience at a hospital and two personal care homes. None of these institutions were contacted by MDC interviewers regarding this person's work history notwithstanding that four of her references were current MDC employees.

[54] For this reason it becomes very important that staff, particularly new staff, be adequately trained.

[55] MDC witnesses contend that Health Care Aide training certification is not particularly useful from MDC's standpoint because MDC residents differ in character from personal care home residents, a dubious distinction in my opinion as there are seemingly obvious similarities between the two care groups. MDC's preferred approach is to train successful PNA applicants on the job. This is accomplished by means of initial orientation sessions where new staff are exposed to the essential job skills and knowledge necessary to perform as a PNA. MDC Staff Development Coordinator Lavone Lesperance-Caron apprised the Inquiry that MDC embarked on a PNA1 upgrading program in May, 2000. She advised that this requires 160 hours of participation in educational programming which is broken into seven sequential training modules. Information relating thereto can be found in Appendix G. For the sake of comparison I have also attached Health Care Aide training materials from Manitoba and Alberta educational institutions as

Appendix H hereto. During the first two years of employment new PNAs are also exposed to a 40-hour PNA foundation course offered by Red River Community College. At the end of this trial period MDC usually confers an in-house certification recognizing the new certified employers' permanent (not term) PNA2 status.

[56] With the exception of fire and hazardous materials handling procedures, MDC does not test staff to determine competent knowledge of significant resident safety related policies/procedures, choosing rather to require staff to periodically refresh themselves with respect to ten key policy areas. All staff are periodically required to read these key policies and sign off respecting their understanding of same. The ten policies currently encompassed are as follows:

1. I-40 Incident/Risk Reporting
2. 1-50 Protection - Resident Abuse/Neglect/Undignified Treatment
3. I-51 Protection of Service Providers
4. I-90 Removal of Government Property From Centre's Grounds
5. I-130 Transportation/Supervision of Residents Off MDC Grounds
6. I-131 Utilization of Motor Vehicles on Government Business
7. II-60 Chemical Impairment in the Workplace
8. V-05 Basic Resident Rights - Meals
9. VII-10 General Safety
10. VII-60 Smoking

[57] In addition to the foregoing it is common practice for MDC's Transportation Services coordinator to send out "reminder" bulletins, usually semi-annually, respecting vehicle safety issues.

[58] MDC's reluctance to formally test employees respecting institutional policies and procedures mainly stems from concerns regarding the logistical difficulties associated with such an approach. There are after all approximately 750 persons on staff, several hundreds of whom have resident care responsibilities. MDC witnesses testified that the institution's preferred educational approach was based on the honour system. Employees are made aware of policy materials and expected to familiarize themselves with same. Caregivers must sign off on

important safety related policy materials. The institution also relies on an advertised open door whistle blowing policy to detect both deliberate and unintentional breaches of safety policies; the assumption being that this approach is conducive to the detection of irresponsible employees. Evidence received at the Inquiry belayed this conclusion. The Inquiry heard that MDC employee culture enhanced suppression of such non-compliance, that it was commonplace for staff both not to follow policies and fail to report in such regard.

[59] Evidence was, for example, received that a certain supervisor neither gave checklists out to escort PNAs prior to resident outings nor asked for return of same on outing returns notwithstanding policy requiring same. Ryan Mooney, one of the employees who was terminated following the MDC investigation of the Robinson incident, who confessed to frequently neglecting to follow policies, was described in a March 19, 2004 MDC investigation report as having a "satisfactory" work record. This opinion was assumably based on an August 2003 practical assessment (Inquiry Exhibit 21) which stated "Ryan ensures a safe and secure environment at all times - ensures that all safety concerns are reported." It is obvious to the writer that this conclusion was factually ill-founded and naively premised on only general impression and illusion. No colleagues ever blew the whistle on Mr. Mooney's transgressions. Indeed, there is no evidence before this Inquiry suggesting that this employee was either aware of or ever familiar with the details of relevant resident safety policies and procedures. In this regard Mr. Mooney conceded that he'd found the initial review of relevant MDC programs and policies "too much to remember" in the relatively short pre-employment orientation period allotted after his hiring. It was this witness's seemingly sincere and constructive suggestion that the new staff orientation/training sessions be delivered over a longer time period.

[60] Another witness, one who had been employed as a caregiver at MDC for well over a quarter of a century, suggested that MDC policy education was of vital importance. It was his opinion that it was important that staff read and understand institutional care policies. Significantly, the same person candidly admitted personal transgressions with respect to resident transportation safety policy, ascribing same to "sheer laziness". Other MDC witnesses made similar admissions.

[61] I have concluded that training and an open door whistle blowing policy are not in and of themselves enough to ensure effective staff compliance with significant resident safety policies. The current approach is defective inasmuch as it is over-reliant on employee cooperation and personal self-discipline.

[62] It is my view that resident safety is simply too important a subject to leave to the vagaries of individual motivation and discretion. As such I suggest the

implementation of a comprehensive care staff testing and assessment program designed to ensure full and ongoing familiarity of such staff with details of all resident safety policies and procedures. Such formalized testing should be accompanied by appropriate training and re-training opportunities for all affected staff persons. Such formalized programming might predictably cause a cultural shock wave at MDC but it is the writer's opinion that this will ultimately serve to benefit the residents of MDC. Because they are so particularly vulnerable to neglect, it is especially important that MDC management adopt the highest standards of vigilance with respect to those charged with their care.

Staff/Resident Ratios – Outings

[63] Several MDC caregivers testified that they had concerns in this regard. The common prevailing theme was the general vulnerability of the resident population. For example, of the eight residents taken on the incident outing, six were described as being non-verbal and two were described as requiring close supervision because of their propensity to run. A senior licensed practical nurse testified that a 4:1 ratio on an outing generally presented supervisory challenges. The witness, who was familiar with all the residents on the February 28th outing, expressed the view that this particular group would be a handful on any outing. It was her view that only four or five residents should have gone on this outing because of the diverse nature of the mix.

[64] Other caregivers expressed similar views. A senior employee, a registered psychiatric nurse, told the Inquiry that only three or four of the eight residents could have been safely taken on the outing by Messrs. Mooney and Simpkins. Evidence received in this regard cited mobility, susceptibility to choking, poor general health and discipline issues as concerns in this regard.

[65] There was general agreement that fixed and inflexible ratio rules would not be the solution to the problem, that the exercise of appropriate judgment by the supervising cottage charge nurse (as is currently required by Policy No. I-130) is preferable, a view which I personally concur with as fixed ratios would lead to invidious and sometimes seemingly unfair decisions by staff; decisions which would probably often be perceived as unfair by "uninvited" residents. That having been said, there will always be a real concern about the possibility of someone running or wandering off even when the utmost care is exercised by staff because of the inherent risks associated with certain residents' proclivities in this regard. For this reason elopement is always a real danger. Indeed, only two or three years ago a resident drove a bicycle off-campus precipitating an emergency search and rescue situation.

[66] Consideration should be given to the acquisition of location monitoring equipment for high risk to run residents. If the purchase and utilization of such GPS based electronic equipment were deemed feasible from a financial and utilization standpoint this well might enhance staff's ability to manage and safeguard against potential tragic outcomes associated with elopement or abandonment risk.

RECOMMENDATIONS

1. Hiring Panels to Contact PNA Applicants' Former Employers

[67] It is recommended that hiring competition panelists contact applicants' former employers and volunteer placements when the applicant's work history discloses prior related employment experience. Such a practice would provide a useful source of information relative to essential selection criteria, i.e., whether an applicant possesses good interpersonal and communication skills and is physically able to perform duties.

2. Public Posting of PNA Position Openings

[68] It is recommended that MDC post all PNA position openings in a timely fashion prior to selecting suitable candidates for interview paneling. Such postings should be province-wide and include advertisements in newspapers possessing such circulation profiles.

3. Mandatory Interviewing of All Applicants Possessing Health Care Aide Certificates

[69] It is recommended that any PNA job applicant possessing a Health Care Aide certificate from a recognized educational institution such as Red River Community College be interviewed. Such persons should by virtue of their extensive related education be *prima facie* presumed to possess the necessary qualifications to satisfy MDC's pre-interview screening criteria. The reader is invited to review Appendix H for details of same.

4. Establish Formalized Caregiver Testing Program at MDC

[70] It is recommended that MDC implement a comprehensive testing program designed to ensure that all caregivers are fully familiar with details of all pertinent resident safety policies and procedures.

5. Amend The Highway Traffic Act to Protect Mentally Challenged Persons

[71] It is recommended that section 186(6) of **The Highway Traffic Act** be amended to include mentally challenged persons who are passengers in motor vehicles. Such a provision would require drivers to ensure that all such persons are secured by a proper seat belt assembly when a vehicle is being driven.

6. Electronic Monitoring on Outings

[72] It is recommended that MDC consider the feasibility of the utilization of GPS wrist or ankle bracelets electronically tuned to pinpoint the whereabouts of the wearer at all times when residents are off campus on outings.

7. Publication of All Disciplinary Sanctions to Caregiver Staff

[73] It is recommended that henceforth MDC publish all caregiver disciplinary sanctions so that staff are aware of consequences resulting from breaches of MDC policies/procedures relative to neglect of duty. Such a practice would assumably have an educative impact that would deter other caregivers from engaging in similar misconduct.

8. Installation of Vehicle Warning Devices Re Unfastened Seat Belts

[74] It is recommended that MDC explore the availability of seat belt warning devices. Such devices would immediately alert escorting caregivers to unsafe situations and ensure optimal passenger safety when residents were on van excursions.

I respectfully submit my recommendations and conclude this Report this 21st day of March 2007, at the City of Winnipeg, in Manitoba.

"Original signed by:"

BRIAN M. CORRIN, P.J.

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